Appendix A: Waiver Administration and Operation
Quality Improvement: Administrative Authority of the Single State Medicaid Agency
Methods for Discovery: Administrative Authority
Sampling Approach: 100% Review
Data Aggregation and Analysis: State Medicaid Agency
Frequency of data aggregation and analysis: Annually
Frequency of data collection: Annually
Data Source Meeting Minutes

Sub-Assurance	Performance Measure	CMS Issue(s)	Possible Resolution/Further Consideration
a) The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.	Of the total number of Division of Developmental Disabilities (DDD) QI committee meetings, the total number of meetings in which the Medicaid Assistance Unit staff participated.	None	Not specifically stated, but certainly need to include the additional information for number of meetings and the proportion of meetings attended to total meetings.

Appendix B: Quality Improvement: Level of Care
Quality Improvement: Level of Care
Methods for Discovery: Level of Care Assurance/Sub-assurances
Sampling Approach: 100% Review
Data Aggregation and Analysis: State Medicaid Agency
Frequency of data aggregation and analysis: As determined by the DD QI Committee and/or Deputy Director

Frequency of data collection: With each waiver eligibility determination
Data Source SharePoint form filled out by DSS group; data is queried
CMS Performance Measures For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Sub-Assurance	Performance Measure	CMS Issue(s)	Possible Resolution/Further Consideration
a) An evaluation for level of care (LOC) is provided to all applicants for whom there is reasonable indication that services may be needed in the future.	The number of new waiver eligibility determinations completed by the disability services specialist within 2 weeks of receipt of all required information	Regarding Sub-assurance (a): dd. The proposed performance measure (PM) does not address whether an evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future. Please revise this PM to specifically address this issue. (#79) ee. The proposed PM should be in the form of a percentage. In its current form, the PM is simply an integer and does not provide a sense of compliance. Please revise the PM to describe the actual measurement to assure compliance.	An evaluation of level of care is provided to all applicants. The performance measure needs to specifically state that. All performance measures should provide a numerator (number of level of care evaluations completed within two weeks), a denominator (total number of evaluations) and a proportion (number of level of care evaluations completed within two weeks divided by total number of evaluations).
b) The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver	Number and percent of waiver participants who have had an annual LOC re-determination within one year of their initial LOC evaluation and within 1 year of their last annual LOC evaluation	None	

Appendix B: Quality Improvement: Level of Care
Quality Improvement: Level of Care
Methods for Discovery: Level of Care Assurance/Sub-assurances
Sampling Approach: 100% Review
Data Aggregation and Analysis: State Medicaid Agency
Frequency of data aggregation and analysis: As determined by the DD QI Committee and/or Deputy Director

Frequency of data collection: With each waiver eligibility determination
Data Source SharePoint form filled out by DSS group; data is queried
CMS Performance Measures For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Sub-Assurance	Performance Measure	CMS Issue(s)	Possible Resolution/Further Consideration
c) The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine the initial participant level of care	Of the total number of LOC eterminations, the number of LOC redeterminations that were completed accurately according to the processes and instruments described in the approved waiver and according to the approved description to determine participant level of care.	Sub-assurance c – The first performance measure does not address whether the instruments described in the approved waiver are applied appropriately. Please revise the proposed measure or add a measure to address this sub-assurance.	

Appendix C: Participant Services

Sub-Assurance	Performance Measure	Data Source	CMS Issue(s)	Possible Resolution/Further Consideration
a) The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.	1. Of the total number of certification/compliance reviews completed on certified provider agencies, the number of providers cited for failure to adhere to required regulations.	Summaries of DD Surveyor/Consultant certification activities	None	
	2. Of the total number of newly certified providers, the number of providers that initially meet required background checks prior to delivery of waiver services.			
	3. Of the total number of certified providers, the number of providers that continue to meet all required certification standards.			
b) The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.	1. Out of the total number of monitorings, the number of SC monitorings that indicate the management of services, supports, and providers is occurring as documented in the service plan.	SC Supervisor service plan review	Regarding Sub-assurance (b): The first proposed PM only mentions background checks. Are there any other waiver requirements that must be met prior to non-licensed/non-certified provider approval? If so, please revise the PM to include those standards.	
	2. Out of the total number of background checks completed on non-licensed/non-certified providers, the number of background checks completed prior to initial provider approval.	With each initial provider enrollment		
	3. Out of the total number of non-licensed/non-certified independent providers, the number of non-licensed/non-certified independent providers that met initial waiver provider qualifications.			
	4. Out of the total number of non-licensed/non-certified independent providers, the number of non-licensed/non-certified independent providers that continue to meet waiver provider qualifications.	With each annual provider reapproval		
c) The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.	Of the total number of certified provider agencies, the number of agencies cited for having no records of staff meeting initial orientation requirements	Service Coordination Monitoring Tool	Regarding Sub-assurance (c):For the second proposed PM, how is it determined that an individual had no issues with their non-certified community supports provider performance?	Non-specialized providers are evaluated by service coordination with indivudals in services and/or their guardians at least twice per year. Perhaps the monitoring process could be included in the narrative of the perfomance measure.
			How does the state measure if an individual had issues with a non-certified provider outside of community supports?	
			As a general matter the number of providers without performance issues is not an adequate proxy for whether the state has implemented its policies and procedures for verifying that provider training has been conducted in accordance with state requirements and the waiver. We recommend that the proposed PM be replaced with one that more accurately measures the sub-assurance.	The state needs to add a performance measure that better measures/identifies that provider training has been implemented in accordance with policies and procedures and would ultimately satisfy CMS.

Appendix D: Quality Improvement:	Participant-Centered Planning and Service Delivery
Methods for Discovery:	Service Plan Assurance/Sub-assurances
Sampling Approach:	100% Review
Frequency of data aggregation and analys	quarterly, semi-annually, or as determined by the DD QI Committee and/or Deputy Director

Appendix D: Participant-Centered Planning and Service Delivery
Data Aggregation and Analysis: State Medicaid Agency
Frequency of data collection: Ongoing and continuously, following each annual and semi-annual service plan team meetings, initiation of the waiver, or
Frequency of data aggregation and analysis: quarterly, semi-annually, or as determined by the DD QI Committee and/or Deputy Director

Sub-Assurance	Performance Measure	Data Source	CMS Issue(s)	Possible Resolution/Further Consideration
a) Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means	1) Of the total number of service coordination monitorings, the number of monitorings that indicate safety issues are being addressed as documented in the service plan	SC monitoring tool - Question a06	Regarding sub-assurance (a): None of the PMs measure whether service plans address all participants' personal goals. We request that the state either revise the current PM or add an additional PM to measure that all participants' personal goals are addressed in the service plan.	SC monitoring tool a07 - Task/activities meet the individual's habilitation needs (challenging, enriching & increasing independence); SC Supervisor service plan review Question 2 - Assessments document strengths, needs and preferences
	2) Of the total number of service coordination monitorings, the number of monitorings that indicate medical issues are being addressed as documented in the service plan	SC monitoring tool - Question a37		
	3) Of the total amount of service plan reviews, the number of reviews that indicate medical services are specified and documented on the service plan.	SC monitoring tool - Question a32		
b) The State monitors service plan developent in accordance with its policies and procedures	1) Of the total number of service plans reviewed, the number of plans that have been determined to be written in accordance with identified DDD policies and procedures.	Review Tool Question - This IPP/IFSP has been determined to meet the minimum DDD standards.	None	
c) Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs	1) Of the total number of service plans, the number of service plans developed by the team annually and reviewed semi-annually	Review Tool Question 1a - At a minimum the IPP/IFSP is developed annually and reviewed semi annually.	Regarding sub-assurance (c): The second proposed PM does not adequately address the sub-assurance. This PM only provides the number/percent of total service plans that were revised due to a change in a person's needs, not the percent of service plans that needed to be revised and were revised. Please revise this PM to appropriately measure the sub-assurance.	The monitoring tool is essentially measuring what CMS is asking for, but for a specific and potentially not all reasons. A performance measure to track the number and proportion of changes needed to service plans for any reason and a performance measure to measure the number and proportion of changes revised for any reason would satisfy the issues.
	2) Of the total number of service plans developed each year, the number of service plans that were revised due to a change in a person's needs	Review Tool Question 5g - The IPP/IFSP was revised due to a change(s) in a person's needs.		

Sampling Approach:	100% Review
Frequency of data aggregation and analys	quarterly, semi-annually, or as determined by the DD QI Committee and/or Deputy Director

Appendix D: Participant-Centered Planning and Service Delivery
Data Aggregation and Analysis: State Medicaid Agency
Frequency of data collection: Ongoing and continuously, following each annual and semi-annual service plan team meetings, initiation of the waiver, or
Frequency of data aggregation and analysis: quarterly, semi-annually, or as determined by the DD QI Committee and/or Deputy Director

Sub-Assurance	Performance Measure	Data Source	CMS Issue(s)	Possible Resolution/Further Consideration
d) Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan	1) Of the total number of service plan reviews, the number of reviews that indicate the authorized units match the state's electronic authorization and billing system	Review Tool Question 7a- The documented authorized units match the state's electronic authorization and billing system.	None	CMS did not mention that the submission only had the number and not the proportion to all service plans. It would make sense to include all factors in the resubmission
	2) Of the total number of approved service plans, the number of plans that reflect services were authorized as specified in the plan.	SC Supervisor service plan review		
e) Participants are afforded choice: Between/among waiver services and providers	1) Number and percent of new waiver participants each year whose records contain an appropriately completed and signed Consent/Request for Services form which offered a choice between institutional and waiver services.	SC Supervisor service plan review/DD Waiver Eligibility Determination worksheet	None	
	2) The number and percent of new waiver participants or their legal guardian if applicable, that participated in making a choice of waiver providers.	Review Tool Question 1b - Individual or legal guardian participated in make a choice of waiver provders.		
	3) Of the total number of individual and family pre-service plan meetings conducted annually, the number of meetings that reflect the waiver participant was afforded choice between/among waiver providers	Review Tool Question 1b - Individual or legal guardian participated in make a choice of waiver provders.		

Appendix F:	Participant Rights

Appendix Seciton	CMS Waiver	CMS Issue(s)	Possible Resolution/Further Consideration
F-1: Opportunity to Request a Fair Hearing	**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.	Please specify the timeframe in which notice is provided. Please specify if the IDR process and timeline is identified and explained in the notice. Please note the IDR process cannot replace the individual's right to a fair hearing. Please explain the statement the IDR 'stays the appeals process".	Generallhy need to be more specific . Need to lay out timelines for IDR/appeal process (where possible). The IDR process does not replace the appeal process. It is dessigned to be an informatl meeting to resolve issues(s) so that a formal appeal in not needed. Just needs to be stated as such.
F-2 Additional Dispute Resolution Process	**Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.	It is clear informal dispute resolution needs to be requested within 90 days of the decision and any remaining time to request a fair hearing is communicated. How long does the IDR process take? Does the state collect data on IDR utilization and the number of decisions that continue through to a fair hearing?	Need to specify the time frames for the IDR process, and then measure compliance to those timelines as part of the state's QI process. The state does collect IDR data and could use this as a performance measure if deemed that it is needed.
Appendix F-3 State Grievance/Complaint System	**Operation of Grievance/Complaint System.** (Yes/No) **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system: **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).	Since the state does not operate a complaint system, how does the state afford participants the opportunity to register a complaint concerning the provision of services under the waiver?	The state does have the ability to build and implement a complaint system that would be capable of satisfying this CMS requirement.